DOCUMENT RESUME

ED 416 623 EC 306 174

AUTHOR Rutman, Irvin D.; Baron, Richard C.; Hadley, Trevor R.
TITLE The Impact of Managed Behavioral Health Care on Rehabilitation Services to Persons with Serious Mental Illness.
INSTITUTION Matrix Research Inst., Philadelphia, PA.
PUB DATE 1997-00-00
NOTE 10p.
AVAILABLE FROM Matrix Research Institute, 6008 Wayne Avenue, Philadelphia, PA 19144; World Wide Web: http://members.aol.com/workmri/mancr.htm
PUB TYPE Information Analyses (070) -- Opinion Papers (120)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Accountability; Behavior Change; Cost Effectiveness; Delivery Systems; *Health Care Costs; *Health Maintenance Organizations; *Mental Disorders; Private Sector; Privatization; *Psychiatric Services; *Psychological Services; Psychosis; Public Agencies; Public Policy; *Rehabilitation; Severe Disabilities

ABSTRACT

This monograph examines issues in the field of psychosocial/psychiatric rehabilitation (PSR) services for people with serious mental illness, placed in the context of a debate within the field about trends toward managed behavioral health care companies. Four main issues are addressed: (1) the degree to which managed behavioral health care companies will assume responsibility for the delivery of rehabilitation services for persons with serious psychiatric disabilities (evidence suggests relatively little involvement); (2) what effects, if any, involvement in PSR by managed behavioral health care companies will have on the nature of PSR services; (3) the security of future funding for PSR services; and (4) whether the basic values and concern for accountability that underlie managed behavioral health care and PSR are sufficiently congruent to permit effective collaboration. The paper concludes that rehabilitation services for persons with serious mental illness are at risk of a diminished financial base, programmatic changes born of cost control imperatives incompatible with the fundamental values of PSR, and the possibility of these services becoming the neglected stepchild of the mental health delivery system. Decision making concerning these issues is seen to lie not at the federal but at the state and local levels. Communication and cooperation among localities are urged. (Contains 14 references.) (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 416 623

The Impact of Managed Behavioral Health Care on Rehabilitation Services to Persons with Serious Mental Illness

Irvin D. Rutman
Richard C. Baron
Trevor R. Hadley

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

GRIFFIN

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

BEST COPY AVAILABLE

EC 306174

Matrix Focus of the Month

The Impact of Managed Behavioral Health Care on Rehabilitation Services to Persons with Serious Mental Illness

Contact: Richard C. Baron
Matrix Research Institute
6008 Wayne Avenue
Philadelphia, PA 19144

Introduction

Over the past five years there has been an explosion of interest in the concept of *managed behavioral health care* and the ways in which this new approach to organizing, funding, and providing mental health programs will impact on the services available to people with serious mental illness. This has been a particular concern within the community of providers of psychosocial/psychiatric rehabilitation (PSR) services, as the mental health landscape has been reshaped around them. Some have urged PSR providers to prepare now for the advent of managed behavioral health care, to reconfigure their services and their marketing approaches to respond to the anticipated interests of the managed behavioral care companies. Others have argued that the interests of the companies are antithetical to the PSR approach and to the needs of persons with serious psychiatric disabilities, and have resisted the encroachment of managed behavioral health care. The intensity of the debate has increased recently (American Managed Behavioral Health Care Association, 1995; American Managed Behavioral Health care Association, 1994), and this article attempts to identify some of the key issues that face the PSR field.

Four broad issues are at the center of concern. *First,* to what degree will the managed behavioral health care companies assume responsibility for the delivery of rehabilitation services for persons with serious psychiatric disabilities? Despite all the preparation for managed behavioral health care in the PSR community, there is no firm evidence that the companies will be significantly involving themselves in the delivery of such care (Landress & Bernstein, 1994). *Second,* should there be an active interest in psychosocial/psychiatric rehabilitation services on the part of the managed behavioral health care companies, will this substantially alter the nature of those services? While some change is inevitable, there is considerable disagreement about whether those changes will be positive or negative. *Third,* will future funding for psychosocial/psychiatric rehabilitation services be secure? Some argue that PSR faces an encouraging financial future, while others argue quite the opposite (Berkman, 1988; Keisler, 1992). *Fourth,* are the basic values and the concern for accountability that underlie managed behavioral health care and psychosocial/psychiatric rehabilitation sufficiently congruent to permit an effective collaboration between the two approaches? Here again, arguments can be made on both sides of the question (American Managed Behavioral Health care Association, 1995).

The Growth of Rehabilitation Services

Rehabilitation services are an essential aspect of a decade-long interest in helping people with long-term mental illness to live successfully in community settings. This concern with rehabilitation , however, is relatively new; earlier, the nation's response to the rapid deinstitutionalization of state psychiatric hospitals in the 1960s and 1970s had been the establishment - primarily with federal and state funds- of community-based inpatient, outpatient and partial hospitalization programs, part of a projected national network of community mental health centers. By the end of the 1970s, however, it was clear to most mental health practitioners, as well as to service consumers and their family members, that these programs did not fully address the pragmatic problems faced by those with serious psychiatric disabilities in the daunting task of adjusting to community life. CMHC programs were primarily clinically oriented, and needed to be supplemented by a range of rehabilitation-focused services that led to more effective and independent living.

Over the past twenty-five years, a widening range of rehabilitation services has emerged: residential and housing services assisting people to live in small group settings or on their own; classes in activities-of-daily-living' to teach people the basics of personal hygiene, financial management, food preparation, public transportation, etc.; academic programming to help people complete or advance their education; socialization experiences to help people strengthen their personal ties to families and friends; employment assistance to encourage people to work; and other program elements -- case management services, special emphases on multiculturalism, sex education, parenting classes, help in addressing stigma at both the societal and personal levels, and more.

Over the past 20 years, these programs have been offered in a variety of settings: in free-standing psychosocial rehabilitation agencies; as part of a community mental health clinic's overall services' within a CMHC's partial hospitalization unit; as consumer-run rehabilitation facilities within a psychiatric hospital. While only a handful of PSR programs targeted to persons with serious psychiatric

disabilities existed in the 1960s, today the International Association of Psychosocial Rehabilitation Services (IAPSRS) - the professional association that speaks for both agencies and practitioners in the field - estimates that there are approximately 3,000 such programs serving tens of thousands of persons each workday (IAPSRS, 1990). Although there are many PSR models from which to choose, the essential thrust of the PSR approach can be characterized as the rapid engagement of individuals in a caring community that seeks to teach needed living skills in the real world' environments of community life.

The funding base for PSR programs historically has been varied and problematic, in part because PSR evolved some time after treatment-oriented inpatient, outpatient and partial hospitalization programs had already dominated available mental health dollars, and in part because PSR funding was supported through state allocations. Most PSR programs maintain themselves by cobbling together state funds, charitable contributions, federal HUD grants, fee-for-service payments from their local Offices of Vocational Rehabilitation, client fees and third-party insurance payments. More recently, funding for these critical services has come to rely heavily upon Medicaid payments, the federal/state health insurance partnership that reimburses health care providers for "medically necessary" services to persons who are poor and/or disabled.

The Medicaid program has been under close scrutiny lately because of the widely accepted need to slow the rapid rate of growth in its expenditures, costs that impact both federal and state budgets. A significant portion of those costs (about 15%) have been expended on mental health and substance abuse services. The fiscal concerns of public policy makers have been spurred by dramatic trends: in 1993 alone, for instance, Medicaid expenditures rose by 29% (The New York Times, 1993), and analysts see no substantial slowing of growth rates in the foreseeable future for either general medical care or for mental health care's proportion of those overall costs.

Current Medicaid expenditures on mental health care can be roughly divided into two unequal parts; first, most Medicaid mental health dollars go toward federally-mandated "medically-necessary" services -- inpatient and outpatient clinics within hospital settings. Second, the federal government permits the states to expand Medicaid services for a range of optional community programs, including inpatient, outpatient, partial hospitalization, case management services and rehabilitation programming. Over the past decade, most states have used these new spending options to fund a growing number of PSR services, fueling expansions in both program scope and federal and state costs. From this perspective, persons with serious psychiatric disabilities who have been able to access this new generation of important Medicaid-funded PSR services have benefited significantly.

From a quite different perspective, however, there is serious concern about the escalation of general health care costs, of which mental health care is only a small part and psychosocial rehabilitation a still smaller part. With the collapse of President Clinton's national health care reform initiative, the states have stepped up their own efforts to control health care costs, and a large number of states have embraced "managed health care" approaches to controlling costs, particularly for Medicaid eligible persons who are poor, elderly, and/or disabled. As part of that effort, a majority of states have begun to consider -- or have already signed contracts with -- managed behavioral health care companies to meet their mental health obligations (Croze, 1994).

Managed Care and Managed Behavioral Health Care

Seen in its most positive light, managed care promises significant cost savings coupled with improved quality of care. Most managed care plans involve some form of capitation: the managed health care provider agrees to deliver all specified health care services for a designated population at a pre-set cost-per-person-per-year fee. Under such a plan, the managed care provider accepts certain risks and has certain incentives: if actual expenditures for the stipulated services exceed the capitated payment, the managed care provider loses money. If, however, actual expenditures for the stipulated services are less than the capitated fee, the managed care provider is usually entitled to retain as profit whatever funds remain. This contrasts dramatically with the current Medicaid system, which (along with most other insurance programs) reimburses the health care provider-at pre-determined fees- for whatever medical services the doctor and/or patient deem necessary. In the managed care scenario, the health care provider

has a strong incentive to control costs.

To control costs, managed health care plans in the medical arena use a combination of mechanisms often referred to as the ABC's of managed care. First, *Access* to services is more tightly controlled; the managed care provider often uses specific protocols that guide Utilization Review staff in deciding which medical conditions mandate which medical procedures before they authorize payment for the service. This clearly shifts final decision-making from either physician (who previously were authorized to determine treatment approaches) or consumers (who increasingly have won the right to influence the nature of their care). Complaints about the Utilization Review process and its shortsightedness are rife. Second, *Benefits* are restricted, with some managed care provides limiting both the array of services that are available and the length of time services can be offered. Employers have reduced the costs of their health care plans for employees, for instance, by contracting with managed health care companies for a more limited range and duration of services than they previously supported. Third, *Costs* for services are reduced by holding down the fees of physicians and other practitioners, as well as clinics and hospitals. The companies use their buying power to contract for care at low rates, which many perceive as also lowering the quality of the services rendered. Nonetheless, managed care companies have demonstrated their ability to diminish the nation's overall health care costs, sometimes dramatically.

As noted above, most states now have some on-going or planned involvement with managed health care companies, primarily through their state Medicaid office, in which the state contracts with one or more companies to provide health care to persons who are poor, elderly and/or disabled on a capitated basis. Although service recipients may chafe at the lack of choice in their plans and the service providers may resent the need to submit their professional judgement to the second-guessing of Utilization Review officers (Austad & Berman, 1991; Austad & Hoyt, 1992; Austad, Morgan & Holstein, 1992; Berkman, 1988), managed health care is clearly a fact of life for general medical service delivery.

Mental health services, however, have been treated somewhat differently. In the private sector -- for instance, in health care plans provided by employers -- managed care companies have often subcontracted with a private managed behavioral health care company to deliver the mental health services required under their contracts with the employer. In the public sector, two contractual patterns currently predominate: first, the state Medicaid office may contract for all health care services with medically-oriented managed care provider, who will subcontract the mental health services portion of their responsibilities to a private managed behavioral health care company; or, second, the state Medicaid office may itself contract for mental health services directly with a private managed behavioral health care company. In either instance, the Medicaid-eligible individual who once received mental health services through the traditional fee-for-service plan is now on a capitated plan and subject to the rules and regulations of the contract between the state Medicaid office and the provider. Similarly, the mental health services provider who was once directly reimbursed for care through the state or county authority or through the Medicaid office must now seek contractual arrangements with the private managed behavioral health care company, subject to the rules and regulations - the ABCs - of managed care.

Of particular importance, is the fact that to date most contracts between state Medicaid offices and managed behavioral health care providers cover only the traditional clinically-oriented services of inpatient, outpatient, and partial hospitalization care; that is, they have not included the delivery of rehabilitative services. Rehabilitation services to the Medicaid-eligible mental health client currently continue to be funded either by state mental health dollars of through separate Medicaid fee-for-service arrangements. While managed behavioral health care companies are very involved in the design and delivery of Medicaid programs that have carved out' clinical services, they have little or no contractual responsibility, at present, to deliver rehabilitation services. They may contract for such services if they choose - indeed, one of the benefits of capitation plans is that managed care organizations are free to utilize any service elements that will benefit the client and lower overall costs - but the managed behavioral health care companies are under no obligation to do so if they believe that neither the client's health nor the companies' profits warrant an investment in rehabilitation services.

Indeed, many of the nation's managed behavioral health care companies acknowledge their uncertainties in this area. The companies are unsure of how to control costs and deliver quality care for those clients

who require ongoing clinical services or long-term rehabilitative care. They are often unfamiliar with the concepts of rehabilitation in general and the benefits of psychosocial/psychiatric rehabilitation in particular. And although the managed behavioral health care companies indicate they may want to refer some portion of their most disabled clients to psychosocial rehabilitation providers, whether they will actually do so - and whether they will feel it necessary to both refer and pay for these services - remains to be seen. Reports from around the nation indicate that managed behavioral health care companies sometimes have drawn PSR agencies into the companies' networks of potential providers, but rarely refer clients to them. The PSR agency may contract with the company on a fee-for-service basis but without referrals the contract prove of little value.

Clarifying the Debate Ahead

The future of rehabiliation servies within the context of a manged behaivoral health care environment is uncertain for serveral reasons:

-first, the term managed behavioral health care' - while widely in use- currently includes a half-a-dozen organizational models under as many different auspices (Keller, McGuirk, & Croze, 1995). The dominant models of managed care range from health maintenance organizations to preferred provider agencies to point-of-service plans, each with differing approaches to controlling costs and monitoring the quality of services. Further, significant differences exist among those managed behavioral health care providers who operate as private for-profit companies, as private non-profit social service agencies, or as county or city governmental mental health agencies seeking new ways to control public expenditures.

-second, changes in the mental health /rehabilitation environment are occurring at a state-by-state (or county-by-county) level, with Medicaid/Managed Care contracts taking widely divergent forms within an often experimental framework. Change is occurring rapidly, and without any existing process for capturing and disseminating policy developments, contract language, regulatory provisions, and policy statements.

-and third, decision-making about the role of managed behavioral health care in the public sector has rarely concerned itself with the impact of these new directions upon rehabilitation services. The scope of the broader mental health issues- that is, the sheer enormity of the dollars involved (at either the national level or state level) in the delivery of clinically-oriented mental health services alone - dwarfs the significance of the rehabilitation dollar. And while psychosocial/psychiatric rehabilitation programs have begun to prepare' for the coming of managed behavioral health care into the rehabilitation field, it is by no means clear what that may mean.

On the fundamental questions of whether managed behavioral health care companies will assume responsibility for the delivery of rehabilitation services, the jury is still out. Most private companies, only now beginning to recognize the importance of rehabilitation services for this group of clients, are more familiar with serving less severely disabled individuals and thus are not oriented to the long-term needs of clients previously treated entirely within the public system. In fact, the behavioral health care industry is almost entirely oriented to the management of episodic care, and as a result, some managed behavioral health care companies will choose to remain separate from the delivery of rehabilitation services, referring their clients in need of such services to either public or private providers of residential, vocational, social and educational care. other companies may come to believe that the delivery of rehabilitation services does offer benefits - both to the client and to the companies' bottom line - and may begin to invest in the provision of such serves to both help disabled person and avoid overwhelming financial costs.

There are several corollary issues that also need to be resolved in the years ahead:

1. How much will managed behavioral health care companies value rehabilitation programming? If the companies believe that rehabilitation programs do indeed quickly decrease hospitalization and increase functional performance, it is likely that they will invest heavily in expanding and enriching such programs, whether by absorbing rehabilitation dollars in their state contracts or by defining rehabilitation as a medically necessary service within their existing Medicaid obligations. But the nature of PSR is

BEST COPY AVAILABLE

based on long-term supports and outcomes and those companies who do not see the cost savings and clinical outcomes promised quickly are likely to de-emphasize rehabilitation programming in favor of still less expensive maintenance services.

2. How will managed behavioral health care companies organize the delivery of rehabilitation serves? The companies will have several options if they choose to offer rehabilitation serves: they can contract (on a fee-for-service or sub-capitation basis) with the existing network of rehabilitation providers; they can absorb those provider agencies within their organizational umbrellas; or they can establish their own internal rehabilitation resources. Theses choices may well impact on program innovation, integrity, and flexibility.

3. Will the nature of rehabilitation programming change in a managed behavioral health care environment? There is considerable concern that the ABC's of managed care may fundamentally alter the nature of rehabilitation service, with access limited to those clients best able to function more independently, benefits limited to short-term interventions with quickly realizable financial and/or clinical outcomes, and costs driven down to a level at which both PSR professionals and consumer-operated program staff believe themselves to be exploited.

4. How strong is the commitment of managed behavioral health care companies to the tenets of consumer empowerment? The delivery of public mental health services has been powerfully influenced over the past decade by consumer empowerment initiatives in which consumers have greater control over the nature and pace of their rehabilitation programs, greater involvement in agency, county, and state policy-making, and greater opportunities to establish non-traditional consumer-operated programs. The companies' emphasis on customer service may well reinforce these trends, or utilization review and bottom-line analyses may de-emphasize them (West Virginia Mental Health Consumer Association Consumer Satisfaction Survey, 1995).

5. If rehabilitation serves are separately funded by the states, how will they relate to managed behavioral health care? While the companies have expressed strong interest in drawing upon the resources of those publicly funded rehabilitation service available, there is no clear pattern yet defining how the two systems will relate to one another, exchanged important information, or collaborate on either individual client goals or intersystem objectives. Some companies are quick, perhaps too quick, to access publicly funded rehabilitation services; on the other hand, some companies have essentially turned a blind eye to their clients' residential or vocational needs - raising a new age-old question about services integration. To avoid clients being excluded from care on the grounds that they are unlikely to benefit from them in a reasonable period of time, a new duality of service systems could develop: managed behavioral health care would deliver clinical programs and the publicly-funded system would provide rehabilitation services. There has been a long struggle between clinical and rehabilitation providers within the nation's mental health system, and only in the past decade have we seen a broadening vision - on both sides - in which the value of both sets of service are recognized.

The concern implicit in all these issues is that companies' pre-occupation with profits and losses will drive PSR services toward contraction - if not extinction. These considerations give rise to a final question: Will there be enough money in the new mental health environment to continue to support rehabilitation programming? Whether or not the managed behavioral health care companies assume responsibility for the delivery of rehabilitation services, it is essential to assure that the still-small and still-insecure funding base for rehabilitation services is not diminished. On this score, it is the states - and not the managed behavioral health care companies- that must be held accountable: first, to insure that the future of rehabilitation services becomes a priority topic, and second, to guarantee that either the companies or the states will continue to support an adequate rehabilitation capacity.

Summary

It is our view that rehabilitation services for persons with serious mental illness are at risk: of a diminished financial base, of programmatic changes (born of cost control imperatives) that are incompatible with the fundamental values of PSR, and of becoming, once again, the neglected stepchild of the mental health delivery system. Further, we believe that decision-making in this arena is not at the

federal level, but rather at the state (and sometimes at the county or municipal) level. For this reason, it is important that the issues and answers that emerge in one setting inform decision-making and cross-constituency discussion in other environments. If promising developments in one community can be shared with other communities, there may yet be an understanding of how best to insure the future of rehabilitation services.

There is some evidence suggesting that there is considerable promise in managed behavioral health care to strengthen, enlarge, and enrich rehabilitation programming, but there is more to suggest that rehabilitation programs may be impoverished or altered beyond recognition. And it may be that these changes will be only short-term; the managed behavioral health care companies may enter the rehabilitation field, only to discover that the profit margins they expect from a field committed to quality services to persons with serious disabilities in need of long-term care is simply too small to warrant their continued involvement. In five years or ten, the delivery of psychosocial/psychiatric rehabilitation services may return to public auspices.

It is important to emphasize that this need not be the case. A wide range of key constituencies could play a more proactive role in assuring that rehabilitation services develop appropriately. As decisions are made - within managed behavioral health care companies, within state mental health and Medicaid offices, and within private rehabilitation provider agencies and public rehabilitation programs - there are opportunities for those who are informed to have an impact. Consumers and family members have the opportunity - both with regard to making personal decisions about their own programs and with regard to raising their voices as part of a broader public policy debate - to shape the services they need. Psychosocial rehabilitation professionals have that opportunity as well.

Bibliography

American Managed Behavioral Healthcare Association (1995). "The AMBHA-NASMHPD Work in Progress White Paper on Public Mental Health Systems, Medicaid Re-Structuring and Managed Behavioral Healthcare." Conference in Alexandria, VA, July.

American Managed Behavioral Healthcare Association (1995). "Managed Behavioral Healthcare Cost Report. Alexandria, VA, July.

American Managed Behavioral Healthcare Association (1995). "Performance Measures for Managed Behavioral Healthcare Programs". Alexandria, VA, July.

Austad, C.S. & Berman, W.H. (1991). Psychotherapy in Managed Health Care. American Psychological Association, Washington, D.C.

Austad, C.S. & Hoyt, M.F. (1992). The Managed Care Movement and the Future of Psychotherapy." *Psychotherapy, 29*(1), 109-117.

Austad, C.S., Morgan, T. & Holstein, L. (1992). Techniques in Independent Practice and Managed Health Care: Interviews with 43 HMO Psychotherapists. Haworth Press, Inc.

Berkman, A.S. (1988). Managed Mental Health Care and Independent Practice: A Challenge to Psychology. *Psychotherapy, 25*(3), 434-440.

Croze, C. (1994). State Health Care Reform for Mental Illness Coverage. National Association of State Mental Health Program Directors, Alexandria, VA.

International Association of Psychosocial Rehabilitation Services. (1990). A National Directory: Organizations Providing Psychosocial Rehabilitation and Related Community Support Services in the United States. Columbia, MD.

Keisler, C.A. (1992). U.S. Mental Health Policy: Doomed to Fail. *American Psychologist, 47*(9), 1077-1082.

BEST COPY AVAILABLE

Keller, A., McGuirk, F. & Croze, C. (March 26 - 29, 1995). Public Managed Mental Healthcare Glossary. Working draft for CMHS Strategic Planning for Mental Care Workshops, San Diego, CA.

Landress, H. & Bernstein, M. (1994). Managed Care 101: An Overview and Implications for Psychosocial Rehabilitation Services. Monograph from the Gulf Coast Jewish Family and Mental Health Services, Inc. Clearwater, FL.

The New York Times, (July 27, 1993). Study Sees Pain Ahead in States' Budgets.

West Virginia Mental Helath Consumers Association Consum Satisfaction Survey. (1995). Chaleston, WV.